THIRD YEAR PSYCHIATRY CLERKSHIP
ORIENTATION SYLLABUS
2015-2016

Welcome to the Department of Psychiatry and the third year clerkship*. We hope that you will find the next six weeks to be both stimulating and rewarding. The faculty, residents, and other staff members will try to help you make the best use of your time during the clerkship. In turn, we hope that you will provide the initiative and hard work that are necessary to learn those aspects of psychiatry which will be helpful to you in future years of practice.

Clerkship Directors and Coordinators:

**Abington Memorial Hospital**
Site Director: Joe Danial, M.D.
Coordinator: Lerah Colman

**Allegheny General Hospital**
Site Director: Gulum Noorani, MD
Coordinator: Suzanne Kodya

**Chambersburg – Summit Health**
Site Director: Satyajit Mukherjee, M.D.
Coordinator: Pam Hildabridle

**Coatesville VA Hospital**
Site Director: Mohammad Qasim, MD
Coordinator: Lori Kutcher

**Drexel University College of Medicine, Friends Hospital**
Clerkship Director: Dilip Ramchandani, M.D.
Coordinator: Carole Szylobryt

**Drexel University College of Medicine, Hahnemann Hospital**
Site Director: Sunil Verma, M.D.
Coordinator: Carole Szylobryt

**Einstein**
Site Director: Kimberly Best, M.D.
Coordinator: Ann Fenstember

**Kaiser Permanente, CA**
Site Director: Robert Ruxin, M.D
Coordinator: Bernadette Sario

**Mercy Catholic Medical Center**
Site Director: Tahir Maqsood, M.D.
Coordinator: Crystal Miller

**Monmouth Medical Center**
Site Director: Shobha Chottera, M.D.
Coordinator: Lizette Boothby

**St. Christopher’s Hospital for Children**
Site Director: Nadine Schwartz, M.D.
Coordinator: Carole Szylobryt

**York Hospital**
Site Director: Constance Ebong, MD
Coordinator: Alexandra Zeigler

*Please DO NOT FORGET TO visit our website at http://webcampus.drexelmed.edu/psychiatry/ for important information that would help you in getting the most out of your clerkship.
The overall goal of the psychiatry clerkship is to enhance the medical students’ ability to effectively identify, evaluate and manage the emotional and psychiatric problems that they will encounter in various types of medical practice.

The goals listed for each competency mirror the goals stated in the Graduation Competencies (i.e., exit objectives) and are modeled on the six ACGME Core Competencies.

The instructional strategies for achieving these objectives include a mix of supervised clinical experiences, bedside teaching rounds, didactic sessions/case conferences, participation in OSCEs, and online readings and lectures. Clinical skills and medical knowledge are assessed through direct clinical observation, student completion of the clinical passport, completion of the med-psych exercise and faculty/resident completion of DUCOM evaluation forms. Medical knowledge is also assessed through the NBME subject examination in Psychiatry.

Patient Care

Goal: Students should be able to participate in providing patient care that is compassionate, appropriate, and effective for the treatment of psychiatric problems and the promotion of mental health.

Objectives: By the end of clerkship, students are expected to be able to:

1. Use appropriate interviewing skills to elicit a comprehensive psychiatric history addressing the onset and course of illness by taking into account all relevant developmental, medical, social and psychological factors.
2. Perform a detailed and accurate mental status examination.
3. Develop a problem list and prioritize problems.
4. Create a sufficiently broad initial differential diagnosis based upon the current DSM.
5. Select, justify, and interpret appropriate diagnostic procedures (including psychological tests, elaboration of history from other sources etc.) and clinical tests with attention to benefits and harms.
6. Use clinical reasoning processes to interpret data to derive a working diagnosis and develop a clinical management plan based on evidence-based medicine.
7. Recognize suicidal behavior and signs of aggression directed at others resulting from psychiatric illness and identify the principles of management of such life-threatening conditions.
8. Recognize side effects and toxic effects of various treatment modalities, including medications, other physical treatments and psychosocial interventions and be able to identify principles of management of their untoward effects.

9. Demonstrate knowledge of the legal issues involved in the delivery of psychiatric care.

10. Participate effectively in the delivery of psychiatric care and discharge treatment plans of assigned patients as a member of the psychiatric treatment team.

### Medical Knowledge

**Goal:** Students must demonstrate knowledge about established and evolving biomedical, clinical, epidemiological, and social-behavioral sciences, as well as the application of this knowledge to patient care.

**Objectives:** By the end of clerkship, students are expected to be able to:

1. Describe common psychiatric disorders, including their characteristic signs and symptoms, etiology, epidemiology, and pathophysiology.

2. Describe the psychological, social, cultural and economic factors that contribute to the onset and/or continuation of psychiatric illness.

3. Describe the role of medical-surgical factors in causing psychiatric illness and vice versa.

4. Describe the principles of management of these disorders using physical and psychosocial treatments.

5. Describe side effects and toxic effects of psychotropic medications, other physical methods of treatment and psychosocial interventions and the basic principles of management of such effects.

### Interpersonal and Communication Skills

**Goal:** Students must be able to demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, their patients families, and professional associates.

**Objectives:** During the clerkship, students are expected to develop the skills to be able to:

1. Demonstrate appropriate verbal and nonverbal techniques to elicit patient history.
2. Use appropriate communication skills to educate patients and to counsel them to modify health risk behaviors.

3. Engage patients and their families, as needed, in the patient care plan and discuss psychiatric information in terms understandable to patients and their families.

4. Demonstrate consideration to diversity in age, culture, disability, educational background, ethnicity, gender, gender identity, race, religion, sexual orientation, and socioeconomic background in communication with patients and their families.

5. Communicate effectively with physicians, other health professionals, and health related agencies in the day-to-day care of assigned patients.

6. Communicate appropriately in difficult situations including: angry and overwhelmed patients, psychotic patients, giving bad news, disclosing medical errors and working with distressed patients and their family members.

7. Articulate an accurate clinical question when requesting consultation.

8. Organize a case presentation to accurately reflect the chronology of the history, the details of the mental status and relevant physical examination findings, the differential diagnosis and the appropriate management plan.

9. Document this information accurately and in a timely manner consistent with the expectations of the clinical service.

**Professionalism**

**Goal:** Students must demonstrate adherence to ethical principles, development of physician attributes, and a commitment to carrying out professional responsibilities.

**Objectives:** During the clerkship, students are expected to develop the skills to be able to:

1. Demonstrate respect for patient, parent, and family attitudes, behaviors and lifestyles, with particular attention to cultural, ethnic, and socioeconomic influences.

2. Demonstrate honesty, integrity, reliability and responsibility in all interactions with patients, families, colleagues, and other professional contacts.

3. Demonstrate behaviors and attitudes that promote the best interest of patients and families and that supersede self-interest.
4. Demonstrate a commitment to ethical principles pertaining to provision or withholding of clinical care, confidentiality of patient information, and informed consent.

5. Demonstrate a positive attitude and regard for education by demonstrating intellectual curiosity, initiative, academic integrity, and willing acceptance of feedback.

6. Demonstrate a professional image in manner and dress.

**Practice-based Learning and Improvement**

**Goal:** Students must be able to investigate and evaluate their approach to patient care, appraise and assimilate scientific evidence, and continuously improve patient care based on self-evaluation and life-long learning.

**Objectives:** During this rotation, students are expected to:

1. Identify strengths and weaknesses in knowledge and skills based on critical reflection and self-evaluation.

2. Seek out opportunities and self-directed learning activities to strengthen deficits.

3. Demonstrate maturity in soliciting, accepting, and acting on feedback in an effort to effectively make improvements.

4. Locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems.

5. Use information technology to access online medical information, support patient care decisions, enhance their own education, and facilitate the learning of colleagues and other health care professionals.

**Systems-based Practice**

**Goal:** Students must demonstrate an awareness of, and responsiveness to, the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care.

**Objectives:** During this rotation, students are expected to:

1. Work collaboratively in inter-professional teams to enhance the quality of patient care.

2. Identify available community resources beneficial in caring for psychiatric patients.
To assist students in acquiring the above competencies, we have distributed a list of terms which we feel students should know (see attached, Important Vocabulary Terms). In addition, please refer to the attached CLINICAL EXPOSURE REQUIREMENTS table which details the numbers and types of patient encounters needed to acquire the competencies for psychiatry.

**The Curriculum:**

The curriculum assignments will vary somewhat from one clerkship site to another. The following information provides general guidelines about the clerkship. You will need to supplement this with written and verbal information provided at the location where you have been assigned.

**Assigned Patients:**

On the inpatient services, you will be expected to follow four or five patients. Your resident or attending will attempt to assign you as broad and varied a range of patients as possible. You will be expected to meet with and assess each patient daily, obtain and interpret the results of laboratory and other ancillary studies, consult with the resident or attending regarding management, and write progress notes as directed by the site director/attending. Some of you will also be getting experience in an emergency room setting. In the latter setting, you will probably have an opportunity to see many of the following problems: active psychosis, delirium, acute stage of drug withdrawal, the management of violent patients and the use of restraints. In addition, you will get experience in gathering data about patients from others in the community, and in community case planning.

**Rounds:**

You will be expected to attend all rounds, make useful contributions, and, periodically, to present new patients. We urge you to take an active part in these meetings for two reasons: learning to communicate verbally with other health care providers is an important part of physician competence; and, in view of the fact that students often spend more time with patients than many other staff members, you often have valuable information about the patient which others need to take into account as treatment plans progress.

**Availability:**

You should be available, whenever possible, when new patients are admitted to your service. If there is a conflict with a scheduled class, seminar, or other departmental activity, you may wish to discuss priorities with your attending or resident. In general, important clinical activities (e.g., the evaluation of a new patient) will probably take priority, but we do not recommend regular missing of
classes and seminars. If problems develop about these priorities, talk to the Clerkship Director or Coordinator.

**Write-Ups and the Patient's Record:**

You will be expected to complete a written report on initial patient evaluations for a minimum of two new patients on the inpatient services. These will be reviewed by the attendings and/or residents who will provide you with feedback. Please use recommended guidelines for write-ups as included in your orientation packet. In most clinical settings, these initial evaluations will not be incorporated into the patient’s medical records although they may be entered into the record at the discretion and approval of the attending provided this option is consistent with the respective hospital's bylaws, EMR practices and/or practice guidelines.

You may be expected to write progress notes (using the S.O.A.P format) in patient charts or EMR systems, as directed by your site director or attending on your assigned patients. Such progress notes should be reviewed and co-signed by your resident or, if no resident is assigned, by an attending. Please date and time each entry. Begin each narrative with "Medical Student Initial Evaluation" or "Medical Student Progress Note", sign your entry, and use "MS-III" after your name.

Since the many hospitals and clerkship sites have different rules for chart entry of student notes, do follow the direction of the site director. **However, it is your responsibility to write at least 2 complete patient write ups and hand them to your supervisors for review and feedback.** We do also encourage students to write progress notes (in a notebook or IPAD that you should keep) after each patient encounter, even if you are not allowed to enter these on the chart. These notes should be used to make your presentations at clinical rounds and to seek feedback from your supervisors. Such notes must be shredded or deleted after your involvement with the patient is complete so that patient confidentiality is not compromised.

Treatment Plans and treatment, or procedure, consent forms, e.g. HIV testing, for patients are reviewed by the resident and/or attending and signed by one or both of them. Students should not be handling the review of such documents with patients in the absence of a resident or attending although we would like you to participate in their development in ward meetings and rounds as directed by your attending.

It is the policy of the Department that third-year students should **not be** asked to dictate/write discharge notes or discharge summaries on any patients.
**Observed Patient Evaluation:**

You will be observed doing a brief (up to 30 minutes) psychiatric interview of a patient toward the latter part of the rotation. The patient should be someone with whom you are not already familiar. This interview can be done during regularly scheduled rounds on the unit or during supervision with your attending. Judging the quality of an interview is a difficult task fraught with variable emphases and biases of individual attendings and residents. In order to try to standardize the evaluation of your interview, we ask you and the observing faculty to use the electronic Interview Evaluation Form “Passport” ([http://webcampus.drexelmed.edu/ClerkshipCompanion](http://webcampus.drexelmed.edu/ClerkshipCompanion)). You are responsible for scheduling the interview session with your attending. Students must pass (receive an “expected” or better rating) this evaluation to pass the rotation. If a student fails an interview session, a new session should be scheduled with your attending as soon as possible, so that a passing grade can be achieved by the end of the rotation. See Medical Interviewing Skills section for detailed information on developing your interview skills.

**Medical-Surgical Psychiatry Assignment (please see appendix for details):**

**OBJECTIVE:** to provide each student with an opportunity to develop and communicate an understanding of evidence-based psychosocial aspects of medical and surgical problems.

**Absences**

**Current Handbook Policies regarding Clinical Rotation Absences:**

**Missed time from Clinical Rotations**

Time away from third year clinical clerkship assignments is not allowed except in the event of illness or emergency. Any absence from clinical clerkships must be documented and approval must be obtained prior to missing clinical responsibilities.

If a student must miss a part of a clinical rotation due to illness or other emergency, he or she must inform the clerkship/course director and any other appropriate individuals responsible for his/her education on that clinical rotation. If the absence is due to illness, the department may request written documentation from a physician. Any absence greater than 2 days must also be reported to the Office of Student Affairs. The department determines how and when missed clinical time will be made up. If the missed time cannot be made up during the remainder of the rotation, the department may elect to submit a grade of Incomplete until such a time as the student satisfactorily makes up the missed clinical experience. Students may not pursue make-up clinical activities for one course while engaged in another rotation.
If you must be absent due to illness or family emergency, please notify your attending, the Site Director and the clerkship director’s office as promptly as possible. The Department may ask for some supporting documentation regarding the reasons for such an absence. Please also see the student handbook for a clarification of this issue.

**Appearance:**

Students are expected to appear in a professional manner during all clerkship assignments. The use of white jackets is optional; check with your attending about his/her preference but please develop a habit of dressing modestly and safely.

**Texts and Resources:**

Many students use abbreviated review books such as the NMS series and Lange Case Files etc. If you limit your reading to one of these books, you will probably be shortchanging your understanding of psychiatric disorders. There are a number of good texts which if read and studied throughout your clerkship, will give you a much better understanding of the diagnosis and treatment of common clinical disorders. The following are recommended:

Kaplan and Sadock: Synopsis, 11th edition, available on line through DUCOM library.


**Other useful books:**

Students have also found Lange Q and A, First Aid – Psychiatry and Case Files to be helpful.

**Students are expected and encouraged to make use of library internet and other reference material to obtain relevant information about assigned patients and/or other aspects of the clinical service to which they are assigned.**

Students are not expected to undertake literature searches for residents or attendings unless the literature search is part of a research or writing project for which the student’s role has been clearly spelled out (e.g. co-authorship).

Didactics: The clerkship sites have traditionally provided classroom lectures that supplement bedside teaching and provide the students with refresher overviews on important topics in clinical psychiatry. To complement any site specific classroom teaching and to assure comparability, we provide students with access to web-based lectures and readings available on the psychiatry
clerkship website. Please use these lectures and readings to supplement your knowledge base.

In addition to the assigned readings, it is a good idea to use the Medline or PsycINFO, to look for current evidence-based research on any aspect of the etiology, diagnosis and treatment of your patient and share your findings with peers and supervisors.

There is no need to acquire a copy of the DSM 5 at this time. Most sites will have copies available for reference.

**Evaluation of Students:**

Your clerkship grade will be based on an assessment of your day-to-day clinical performance; and the grade on your end-of-clerkship written examination (see “Final Grade” below). In order to complete the clerkship satisfactorily, each student must demonstrate both satisfactory clinical performance and successful passing of the written examination.

A. **Assessment of Clinical Performance:**

A major portion of your assessment during your rotation is based on observation of your day-to-day performance. We are especially interested in how well you are able to demonstrate knowledge, skills and attitudes which are appropriate to your level of training. Your day-to-day performance will be evaluated mainly by your attending with the assistance of residents with whom you have worked.

We require you to get mid-clerkship feedback during your rotation. Please remember that this feedback is not a preview of your final summary evaluation which is arrived at by the site director upon reviewing your overall performance and receiving input from many team members that you will interact with during the rotation. The purpose of this meeting is to identify those gaps or aspects of your performance that you will have the opportunity to remediate by the end of your rotation and, most importantly, it is an opportunity to self-assess your own development in the rotation and identify areas that you need to continue to work on. It is your responsibility to send this to the coordinator, Ms. Szylobryt.

B. **Written Examination:**

The final examination will be held on the last day of the rotation. We are currently using the National Board (NBME) Subject Examination in Psychiatry. Students will be required to obtain a score at or above the 10%tile as a condition of passing the clerkship. The examination will be administered at Allegheny General Hospital in Pittsburgh and, in Philadelphia at the Queen Lane
campus. Please contact the local coordinator for details about the time and location.

C. **Medical-Surgical Psychiatry Assignment (Med/Surg):**

This assignment must be completed satisfactorily before a grade can be sent to the Dean’s office.

D. **Observed Patient Evaluation:**

Students must pass the interview session to pass the rotation.

E. **Patient Logs**

We require that you keep an ongoing Palm-based log of all patients with whom you have significant contact; you should be prepared to upload your logs to the web and turn your keys in the day before the final examination. We monitor your logs during your clerkship to assure adequacy and comparability of your training experience across clinical sites.

* If the students do not submit the patient logs within seven days of the end of the clerkship, they will be assigned a “Marginal Unsatisfactory” grade. When remediated, this will result in a revision of the “MU” merely to a “Satisfactory” regardless of the performance on the clinical and the Shelf examination components.

* See attached Problem List for Common Diagnoses seen in psychiatry.

**Final Grade:** (Please note that NBME will use a new score scale for the shelf exam next year so the resulting changes will necessitate re-wording of the shelf exam score requirement)

Your overall clerkship grade combines the assessment of your day-to-day performance and the results of your written examination. Students who demonstrate major knowledge deficits on the written examination are asked to undertake additional studies and to repeat the written examination.

- Please note that no student can receive a satisfactory grade on the psychiatry clerkship if they do not receive a score at or above 62 on the written examination.

- In order for a student to receive Honors, the clinical grade must be 4.0 or above and the shelf exam score must be equal to or above a score of 82.

- In order for a student to receive Highly Satisfactory, the clinical grade must be 3.5 or above and the shelf exam score must be equal to or above a score of 76.
- Grade will be incomplete if logs are not uploaded and you do not get a passing med/surg grade.

**Appeal of Final Grade:** Although the faculty is committed to effectively and fairly evaluating and grading the students, should you feel strongly that a reevaluation is necessary, please email Dr. Ramchandani with a detailed explanation of why you feel that your grade should be elevated. He will review your evaluations and respond to your appeal as soon as feasible. Please also see the student handbook for a clarification of this process.

**Evaluation of the Clerkship by Students**

The clerkship is undergoing continued reevaluation by the faculty and we much appreciate your ideas, criticism, and suggestions. Also, you are encouraged to not wait until the end of the clerkship to contact Dr. Ramchandani if you find that there are obstacles that will prevent you from achieving the stated objectives of the clerkship. Please contact him proactively so an attempt is made to solve any such difficulties in a timely manner.

**Miscellaneous**

**Confidentiality:**

The practice of medicine requires careful attention to maintaining confidentiality of the patient's contact with the physician. Please refrain from discussing patients and patient related issues in public areas of the hospital and to persons who should not have access to information about patients.

Please be especially careful about conversations in the cafeteria and hallways where patient relatives and other visitors may overhear you. The latter settings have an important public relations aspect; patients' relatives make judgments about the degree of interest of the staff in their sick relative based on their observations of the behavior of medical and support staff in the elevators, hallways, the gift shop, and elsewhere.

**Starting Out:**

We recommend that you begin to see your patients as soon as possible. We further recommend that you tag along with your resident for the first week or so to get a feel for how to relate to the patients and what types of findings are important; you may want to forego writing progress notes during the first few days.
Talking with patients: we hope that you will not be needlessly apprehensive about speaking to psychiatric patients. The use of tact and good sense as you would with any patient will greatly facilitate your interactions with psychiatric patients.

Assaultiveness of Patients:

In general, psychiatric patients have not been shown as a group to be much more aggressive than the general population; often, psychiatric patients have become victims of aggression by others. However, we do at times have assaultive patients in the hospital, particularly in the ICU and in the psychiatric emergency services units. Ask the staff about patients with whom you are unfamiliar before undertaking an evaluation of the patients. Avoid solo interviews with new patients whom the staff feel might be assaultive. In addition, pay attention to any feelings within yourself about safety issues; if you feel unsafe with a patient, rearrange your evaluation so as to conduct the interview in a more public space or do so with other staff members close by.

Student Membership in the American Psychiatric Association:

The American Psychiatric Association (APA) offers free student memberships which include subscriptions to the American Journal of Psychiatry, Psychiatric News, Psychiatric Residents Newsletter, and Spectrum. You would also be eligible to attend the APA Annual Meeting without having to pay a registration fee.
Vocabulary and Interviewing (Based upon the compilation by Bryce Templeton, M.D. and other sources as acknowledged)

IMPORTANT VOCABULARY TERMS:

The following terms are regarded as part of the learning objectives for the junior clerkship in psychiatry. With respect to each term listed, you should be able to define it; and/or if given an example illustrating the term or concept, you should be able to correctly label the example. This list does not include DSM-5 diagnostic terms and psychotropic drugs which are also important.

abstract thinking
acting out
adjustment disorder
affect, flattening of
akathisia
akinesia
alexithymia
amnestic syndrome
anhedonia
anticholinergic effect
apathy

behavior therapy
biogenic amine hypothesis

catatonia
circumstantiality
cognitive behavior therapy (CBT)
competency and capacity to make decisions
confabulation
controlled substance
coprolalia
countertransference


crack


crisis intervention

déjà vu
delirium
delusion
delusion, mood incongruent
delusion, shared (aka folie a deux)
delusion, somatic
dementia
denial


Diagnostic and Statistical Manual of Mental Disorders (DSM)
dissociative disorders
Drug Enforcement Administration (DEA)
dual diagnosis
echolalia
echopraxia
ego
ego defense mechanism
ego-dystonic
ego strength
ego-syntonic
empathy
euthymic
extrapyramidal syndrome
false negative
false positive
flight of ideas
freebase
frontal lobe syndrome
Ganser's syndrome
gender identity
hallucination
hallucination, hypnopompic/hypnogogic
hashish
hypomania

id
idea of reference
illusion
Psychiatric Interview

Purposes of the Interview

- Collect Information that is as accurate as possible, develop and test hypotheses,

- Establish a therapeutic alliance – respectful attention, compassion but watch out for false or premature reassurances, attention to appropriate
doctor-patient boundaries, attention to your own safety, awareness of strong transference and counter-transference feelings, attention to cues provided by patient.

Points to consider

Context in which the symptoms developed and emerged is important – why now?

Pay attention to the longitudinal view of the patient’s story! Mental Status Examination, on the other hand, is a cross-sectional view of the patient i.e. how does s/he come across to you during the interview.

Often the patient will not spontaneously provide a linear chronology. There may be a lot of “back and forth”
One must also ask for and listen for emotional aspects
Be patient and pay attention!
Stated reason for seeking psychiatric help – remember that it isn’t always the major problem, it might be a “ticket into the system”. It is the patient’s way of stating this reason that is often an important clue

Outline for a Psychiatric Evaluation

List of chief complaints or symptoms that you arrive at after you have interviewed the patient – not necessarily the same as the “stated reason” for seeking psychiatric attention

History of Present Illness

- Onset of symptoms – when was the patient symptom free?
- Chronological evolution of symptoms, presence of related symptoms e.g. in a depressed patient one would ask for the presence of DSM 5 criteria of major depression such as duration, vegetative symptoms, suicidal ideation etc.
- What preceded the illness? Psychosocial stressors - can be either “positive” or “negative”? Associated substance use/abuse? Associated medical illnesses
- What reaction and understanding has there been to the illness? How has the patient tried to cope with the illness? Has he sought any treatment? If so, what and where?
- If the patient is currently admitted, the course of treatment and response to it should be obtained
Past Psychiatric History - How has the person gotten to this point?
  o The longitudinal, or temporal, context is very important
  o Have there been similar symptoms in the past? How treated? Periods of remission? Progression? Complications? Diagnoses?
  o Related symptoms in the past – if patient has depression, has he suffered manic episodes?

Substance Use, Abuse and Dependence History: onset, duration, course, evolution of use from one drug to others, medical, psychological, social and legal sequelae including withdrawal reactions, treatment history e.g. outpatient/inpatient rehab, AA etc.
  o Alcohol
  o Drugs – street
  o Drugs – prescription
  o Tobacco, Caffeine
  o OTCs and Herbals

Family Psychiatric History - parents, sibs, and child: who had what illnesses & how severe (often determined by the type of treatment that they received e.g. hospitalization); who died and when, etc

Current and Past Medical/Surgical History – some illnesses and/or their treatment (multiple sclerosis, high-dose steroids) may have direct psychiatric morbidity, other illnesses may serve as stressors

Developmental and Social History – chronological biography of patient, major milestones; important relationships, and major life crises
  o Early childhood/adolescence history including neglect and abuse, other traumatic or unusual experiences
  o Family of origin and current family constellation
  o School and academic accomplishments and liabilities
  o Social - Intimate, loving, supportive relationships, companions, lovers, roommates etc.
    (the good, the bad and the ugly)
  o Sexual
  o Employment, career goals, accomplishments
  o Entertainment, leisure time, hobbies, religion, community
  o Diet, physical exercise, regard for safety
Why do we reinforce need for CHRONOLOGICAL? You are less likely to miss important pieces of information.

Review of systems

- A step-by-step list of questions covering major organ systems
- Essential for the sake of completeness.

Collateral information - extending the context

- Family
- Caregivers
- Other providers of professional services
- Old records
- Social workers, case managers etc.

Mental Status Examination

Appearance and Behavior

- Identifying and unique physical characteristics
- Speech – pace, quality – e.g. talkative or taciturn, clarity, spontaneity, emotional tone, impairments e.g. muteness
- Cleanliness and Grooming, appropriateness of dress
- Eye contact
- Motor activity- agitation, restlessness, slowing, abnormal movements – voluntary and involuntary e.g mannerisms, catatonic symptoms, parkinsonism, akathisia, akinesia, dyskinesia, tics, mannerisms

Attitude toward the examiner

- Cooperative or compliant
- Engaging
- Hostile
- Fearful
- Seductive
- Reluctant

Mood and Affect

Mood

- Internal emotional state based on the patient’s statement
- Current and recent
Affect – quality, range and appropriateness

- External manifestation of emotional state
- Happy? Sad? Angry? etc
- Appropriate to mood, situation, congruous with thought content?
- Range of affect - Labile? Constricted?

Thinking

Thought process – logic, stream, abstraction and any special characteristics

- Poverty
- Flight of ideas
- Circumstantial
- Tangential
- Loosening of association
- Blocking
- Word Salad
- Neologisms
- Other idiosyncrasies e.g. clang association
- Logic
- Capacity for abstraction – concrete or overly abstract

Thought content – problems of conception and perception

- Preoccupations, current worries
- Obsessions, superstitions, strong beliefs,
- Delusions
- Hallucinations
-Suicidal and homicidal thinking, intent

Sensorium and Cognition – Folstein’s “mini-mental status examination” is often used to get a standardized measure of cognition

- Alertness-level of consciousness
- Orientation
- Concentration – attention
- Memory – immediate, delayed, long-term
- Abstract thought
- Reading and writing
- Visuo-spatial ability
- General fund of knowledge
- Calculations and problem solving
- Insight - is patient aware that there is a problem, if so, nature of the problem and, lastly, the cause of the problem
- Judgment –general and specific
- Reliability as a historian
Suicidal Patient-Assessment of Suicide Risk (Source: adapted from Thienhaus and Piesecki 1997)

Determine severity of stressors & suicide precipitants
  o Identify accompanying psychopathology (inc. substance abuse) & associated risks
  o Assess whether a patient who is suicidal has access to weapon
  o Assess how realistic the patient’s plan is
  o Outline personal deterrents to committing suicide
  o Recognize limited benefit of labeling patient’s behavior as manipulative
  o Consider situation awaiting patient after discharge
  o If unsure of level of risk, request a second opinion
  o Do not discharge an intoxicated patient
  o Document disposition and its rationale

PHYSICAL EXAMINATION AND LABORATORY/IMAGING RESULTS - if not performed by you, please obtain a summary of it from patient chart

LABORATORY AND OTHER ANCILLARY STUDIES (Source APA- www.psych.org)

Suggested for All Psychiatric Admissions
• Hematology group (HB, HCT, RBC indices, leukocyte count & differential, platelets)
• Chemistry group (electrolytes, LFTs, glucose, Ca, renal function tests, serum proteins)
• Serum B12 and folate
• Syphilis serology
• Thyroid function tests (total thyroxine and TSH)
• Erythrocyte sedimentation rate
• Urinalysis

Consider, Depending on Presentation

Blood
• HIV antibody screen
• Cortisol (AM and PM)
• Drug levels of psychopharmacologic agents
• Drug levels of agents of abuse
• Serum copper and ceruloplasmin
• Autoantibody screen and Ig’s
• Cultures for infectious agents

Urine
• Urine drug abuse survey; urine screen for drugs or toxic agents
• 24-hour urine levels for lead, mercury, arsenic, other heavy metals
• 24-hour urine porphyrin levels
• Urinary metanephrines or 5-hydroxyindoleacetic acid
• Culture for infectious agents

**Imaging**
• *Computer tomography or magnetic resonance imaging of head
• *Chest radiography
• Cerebral angiography
• Cerebral blood flow studies

**Other**
• *Electrocardiogram
• Electroencephalogram
• Cerebrospinal fluid exam for cell count, cytology, glucose, protein, immunoglobulins, cultures
• *Neuropsychologic testing
• Karyotype, specific genetic tests (e.g., fragile X)
• Evoked potentials

**If Alcoholism Is Suspected, Add**
• Blood alcohol level
• γ-Glutamyltransferase
• Triglycerides

**For Nutritionally Depleted Patients, Consider**
• Zinc, copper, carotene, iron, or serum transferrin levels
• Triiodothyronine
• Total serum protein, albumin/globulin ratio
• Basal metabolic rate
*Suggested for evaluation of dementia.*
**Psychiatric Diagnosis and Treatment:**

After you have elicited a thorough history, performed a mental status examination, taken into consideration a review of systems, physical examination findings and laboratory and ancillary studies, you will be able to develop a psychiatric diagnosis based upon the current DSM. This diagnosis should guide you in understanding and developing a treatment plan for the patient that would include various therapies such as individual, group, family, milieu, psychotropic medications and a plan for monitoring the response to these interventions.

The patient’s response to treatment will, in turn, help you to appreciate and participate in a plan for discharge of the patient with appropriate referrals outside the hospital.

### Psychiatry Clinical Exposure Experience Requirements

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Minimum # of contacts</th>
<th>Minimum # Real</th>
<th>Minimum # Virtual or Lecture Self Study</th>
<th><em>Self-Directed Learning</em></th>
<th>Clinical Setting</th>
<th>Level of Responsibility O/A/P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abuse/dependence – alcohol/drugs</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>Pgs 381-390 Pgs 395-409</td>
<td>I/O</td>
<td>O/A/P</td>
</tr>
<tr>
<td>Acute Stress Disorder</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>Pgs 612-621</td>
<td>I/O</td>
<td>O/A/P</td>
</tr>
<tr>
<td>Attention deficit/hyperactivity disorder</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>Pgs 1206-14</td>
<td>I/O</td>
<td>O/A/P</td>
</tr>
<tr>
<td>Bipolar disorder, mania or depression</td>
<td>2</td>
<td>2</td>
<td>0</td>
<td>Pgs 527-557</td>
<td>I/O</td>
<td>O/A/P</td>
</tr>
<tr>
<td>Conduct disorder</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>Pgs 1218-21</td>
<td>I/O</td>
<td>O/A/P</td>
</tr>
<tr>
<td>Delirium</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>Pgs 319-344</td>
<td>I/O</td>
<td>O/A/P</td>
</tr>
<tr>
<td>Dementia</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>Pgs 319-344</td>
<td>I/O</td>
<td>O/A/P</td>
</tr>
<tr>
<td>Eating Disorders</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>Pgs 721-739</td>
<td>I/O</td>
<td>O/A/P</td>
</tr>
<tr>
<td>Condition</td>
<td>Clerkship</td>
<td>Pgs</td>
<td>Obse</td>
<td>Asst</td>
<td>Pfo</td>
<td>Obs</td>
</tr>
<tr>
<td>-----------------------------------------</td>
<td>-----------</td>
<td>-------------</td>
<td>--------</td>
<td>-------</td>
<td>------</td>
<td>-----</td>
</tr>
<tr>
<td>Depressive Disorders</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neglect of Child</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anxiety Disorder</td>
<td>2</td>
<td>2</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Panic Disorder</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personality disorders (borderline, antisocial, etc.)</td>
<td>2</td>
<td>2</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pervasive Developmental Disorders</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical/Sexual Abuse – Child &amp; Adult</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Post traumatic stress disorder</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Schizoaffective Disorder</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>2</td>
<td>2</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Somatoform Disorders</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Suicidal Ideation</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Involuntary Commitment</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adverse effects of Psychotrope Medication</td>
<td>3</td>
<td>3</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Use of Restraint/Close Observation</td>
<td>2</td>
<td>2</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Kaplan & Sadock: Synopsis of Psychiatry, 11th edition – available on Drexel Library online site [https://innoserv.library.drexel.edu/record=b2282201~S9](https://innoserv.library.drexel.edu/record=b2282201~S9).*  
I-Inpatient O-Outpatient